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| C. AMILLING ADDRESS tincius ZIP Code)  d. OFFICE TELEPHONE NUMBER  6. EXPENDITURES (If lare claimed in col. (g) exceeds charge for one person, show in col. (h) the number of additional persons which accompanied the claimant of claimant.)  ONTE  ONTE  A—Local travel  B—B-Isliephone or telegraph, or C. Cherr Experies (finance)  (c) C-Inher Experies (finance)  (d) C-Inher Experies ( |   |                                    |                         |                                       |                            | acy Act Statemer                         | nt on the bac                  | ck of thi                             | is form.                    |                                       |                 | 5. PAID                               | BY       |          |                 | <u> </u>          |           |  |
| 6. EXPENDITURES (If fare claimed in col. (g) exceeds charge for one person, show in col. (h) the number of additional persons which accompanied the claimant.)  ONTE   C   |   | a. NAME                            | (Last,                  | first, middle                         | initial)                   |  | b. SOCIAL SECURITY NO.         |                                       |                             |                                       |                 |                                       |          |          |                 |                   |           |  |
| DATE    A   Cocal travel   B   College   Colle |   | Section 2015                       | 31.5°                   |                                       |                            |  | 1 - A                          |                                       |                             |                                       |                 |                                       |          |          |                 |                   |           |  |
| C ALocal travel BTelephone or telegraph, or C Other Expenses (ifemized)  (a) FROM (d) TO       |   |                                    | IIUR                    | claiman                               | •)                         |  | charge for o                   | ne pers                               | on, show in co              | l. (h) th                             | e number o      | of addition                           |          |          |                 |                   | pani      | ∍d th  |
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STD FORM 1164, AUG. 1970 TITLE 7, GAO MAN. 1164-209

EXCEPTION TO SF 1164 APPROVED BY NARS 4-81

STANDARD FORM 1164 (Rev. 11-77) Prescribed by GSA, FPMR (CFR 41) 101-7

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| CLAIMANT   |                                 |                    |               | ude ZIP Code  |   |                    |          | d. OFFICE TELE            |            |   |                           |          |                             |             |                                       |             |
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| 3. Th  | is claim                        | is app             | proved. Lo    | ong distanc   | f), (g) and (i).) \$                                      | s, if shown, a     |          | 10. I certify             | that this  | s claim is tr                           | ue and co                 | rrect to | the best                    | of my l     | know                                  | ledg        |
| di:<br>au  | stance c<br>thorized            | alls ar<br>I, in w | e include     | d, the appr   | t of the Governm<br>oving official mu<br>f the department | ist have been      | , ,      | and bell                  | er and i   | that paymer                             | nt or creat<br>n Original |          | ot been i                   | receive     | а ву і                                | me.         |
|  |                                 |                    |               | Sign Origi  | nal Only  |                    |          | CLAIMANT<br>SIGN HERE     | •          | ı                                       |                           |          |                             | DATE        |                                       |             |
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| 164-2  | 10 S/N 0                        | 104-LF-            | 800-0077      |   | STD FORM 11   | 64. AUG. 1970      |          | EXCEPTION                 | TO SF 11   | 64                                      | HAATS                     | DARD FO  | RM 1164                     | (Rev 11     | 77)                                   |             |

TITLE 7, GAO MAN. 1164-209

APPROVED BY NARS 4-81

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|   | Ē  |  | es in specific detail.)                        | \$ \$  | MILEAGE        | OR 1        | RE<br>OLL | ADD.<br>PER-<br>SONS | TIPS AND<br>MISCEL-<br>LANEOUS |  |  |
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|   |  | Total each   | n column and enter on the front, subtotal line |  |                |             |           |                      |                                |  |  |

In compliance with the Privacy Act of 1974, the following information is provided: Solicitation of the information on this form is authorized by 5 U.S.C. Chapter 57 as implemented by the Federal Travel Regulations (FPMR 101-7), E.O. 11609 of July 22, 1971, E.O. 11012 of March 27, 1962, E.O. 9397 of November 22, 1943, and 26 U.S.C. 6011(b) and 6109. The primary purpose of the requested information is to determine payment or reimbursement to eligible individuals for allowable travel and/or other expenses incurred under appropriate administrative authorization and to record and maintain costs of such reimbursements to the Government. The information will be used by Federal agency officers and employees who have a need for the information in the performance of their official duties. The information may be disclosed to appropriate Federal, State, local, or foreign agencies, when relevant to civil, criminal, or regulatory investigations or prosecutions, or when pursuant to a requirement by this agency in connection with the hiring or firing of an employee, the issuance of a security clearance, or investigations of the performance of official duty while in Government service. Your Social Security Account Number (SSN) is solicited under the authority of the Internal Revenue Code (26 U.S.C. 6011(b) and 6109) and E.O. 9397, November 22, 1943, for use as a taxpayer and/or employee identification number; disclosure is MANDATORY on vouchers claiming payment or reimbursement which is, or may be, taxable income. Disclosure of your SSN and other requested information is voluntary in all other instances; however, failure to provide the information (other than SSN) required to support the claim may result in delay or loss of reimbursement.

## ANNUAL CERTIFICATE OF PHYSICAL CONDITION

| Date |   |  |
|------|---|--|
| Date | • |  |

## Instructions:

This certificate is to be completed annually by members of the naval service (including Reserves) as required by the Manual of the Medical Department and other directives, as appropriate. The intentional failure to disclose an illness or disease could be construed as an intent to defraud the Government and could result in the member's loss of disability benefits or be the basis for criminal prosecution or other administrative action under the Uniform Code of Military Justice.

Type or clearly print member's name (last, first, middle initial); social security number; and unit to which assigned.

The member shall complete the appropriate responses, sign in ink, and date.

| 1. Last Name, First Name, Midd  | le Init.                  |  |             | 2. SSN 3. Rate/Rank        |                |          |          |                   |  |
|---------------------------------|---------------------------|--|-------------|----------------------------|----------------|----------|----------|-------------------|--|
|                                 |                           |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
| 11000150                        |                           | 5.0                                    | C 455       | 7. Date of                 | Righ           |          |          |                   |  |
| 4. Designator/MOS/NEC           |                           | 5. Sex                                 | 6. Age      | 7. Date of                 | Diffi          |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
| 8. Known Allergies              |                           |  |             | 9. Unit or                 | School and l   | JIC      | 3        |                   |  |
| g                               |                           |  |             | ,                          |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
| 10. Home Address                | ;                         | Street                                 |             |                            | City           |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
| 11. State Zip +                 | 4 Code                    |  |             | Home Pho                   | ne Number      | V        | Vork Pho | ne Number         |  |
| The State                       | 4 0000                    |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
| 12. Location of Health Record   |                           |  |             | 13. Locati                 | on of Dental I | Record   |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             | 15 Durnes                  | o of Evamina   | ution    |          |                   |  |
| 14. Date of last Complete Physi | cai Exam                  | imation                                |             | 15. Purpose of Examination |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
| 16. Date of last Dental Exam    | 17. Type                  | of Examir                              | nation      | 18. Class                  | 19. Date of    | last     | 20. Da   | te of last        |  |
|                                 |                           |  |             |                            | PAP and re     | esults   | Mamm     | ogram and results |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             |                            |                | 1        | <u> </u> | I                 |  |
| 21. Date of last HIV Blood Test | d Pressure<br>serves Only | e 23. Body Fat % 24. Height 25. Weight |             |                            |                |          |          |                   |  |
|                                 |                           | l nes                                  | oerves Only |                            |                |          |          |                   |  |
|                                 |                           |  |             |                            |                |          |          |                   |  |
|                                 |                           |  |             | L                          |                | <u> </u> |          | l                 |  |

(Continued on Reverse)

## ANNUAL CERTIFICATE OF PHYSICAL CONDITION 1. Here you had any injury illness or disease within the past 12 months which required hospitalization or caused.

| 1. | Have you had any injury, illness or disease within the past 12 months which required hospitalization or caused you to be absent from school, duty or civilian occupation for more than 3 consecutive days? |
|----|--|
|    | ( ) NO ( ) YES If yes, explain:  |
|    |  |
|    |  |
| 2. | Are you now, or have you been under a physician's care during the past 12 months?  ( ) NO ( ) YES If yes, explain:   |
| 3. | Have you taken prescription medications in the past 12 months?  ( ) NO ( ) YES If yes, what are they?  |
|    |  |
| 4. | Do you have any physical defect(s), family or mental problems which might restrict your performance on active duty or prevent your mobilization?  ( ) NO ( ) YES If yes, explain:                          |
| 5. | Additional comments:   |
|    | oon completion of indicated action, file completed certificate in member's Health Record and a copy in member's ental Record.  |
| Ιc | ertify that the information contained in this form is true and complete to the best of my knowledge and belief.  |
| M  | EMBER'S SIGNATURE:   |
| M  | EDICAL DEPT. REP. SIGNATURE:   |
| RE | EVIEWING OFFICER'S SIGNATURE:  |
| RE | EVIEWING OFFICER'S COMMENTS:   |
|    |  |
|    |  |